Cuerden Developments Ltd

Cuerden Developments Limited - Alexandra Court

Inspection report

Alexandra Court
Howard Street
Wigan
Lancashire
WN5 8BH

Tel: 01942215555
Website: www.cuerden.com

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Alexandra Court is a 40 bed intermediate care centre providing a time limited period of assessment and rehabilitation for people being discharged from hospital. People access this service because they are not ready to return home safely or to have physical therapy and rehabilitation.

In response to concerns about a specific incident, we carried out an unannounced comprehensive inspection of Alexandra Court on 8 and 9 January 2018.

The service had received a coroner's Regulation 28: Report to prevent future deaths. A person using the service had slipped from a standing hoist on three occasions, the coroner found this had contributed to the persons death. The coroner also found staff were not adequately trained and had failed to keep proper records of the events. We found the service had responded effectively to this and addressed the concerns raised about training in moving and handling and record keeping. Further improvements had also been made in relation to communication between the health and social care staff.

The service was last inspected in June 2016 when it was rated as good overall with a breach of Regulation 12 of the HSCA 2008, safe management of medicines.

At this inspection we found the service had made improvements in the management of medicines but there remained some risks in relation to the storage of medication for people who were self-medicating. The service addressed this immediately following the inspection and installed lockable cabinets in the bedrooms. We also found there were some anomalies and gaps in the records for medication and topical creams.

This was a continued breach of HSCA (2008) Regulation 12(2)(g) the proper and safe management of medicines. You can see what action we asked the service to take at the end of this report.

The people we spoke with reported feeling safe. There was a safeguarding policy in place and staff were familiar with what might be a safeguarding concern and how to report this. There was a whistleblowing policy displayed in communal areas, the staff we spoke with reported knowing how to raise concerns. People who used the service and visitors also had access to this information.

Risk assessments and plans to manage identified risks were completed for people using the service. We saw that these were reviewed and updated at regular intervals.

Assessments of health and social care needs were completed on admission and we could see that people were closely involved in these. Discharge and goal planning was completed within 48 hours and people using the service told us they had felt supported to get back home and kept informed of progress.

Staff had received appropriate training and records showed that they were up to date with refresher

training. Staff were also encouraged to suggest areas of interest for training sessions to develop their knowledge further. Staff reported that they had received good training and felt confident that their practice had improved as a result of this.

The staff were knowledgeable about the Mental Capacity Act 2005 and their obligations under it. Staff were clear about seeking consent from people using the service. The provider was aware of their obligations under the Deprivation of Liberty Safeguards though at the time of inspection there was nobody who was subject to this.

People using the service said that the food was fine and they had plenty to eat and drink. Support was provided for people needing help to manage their food and drink intake. The records were not always completed by the staff. There had not been any harm identified, such as dehydration which indicated that this was a record keeping error.

This was a breach of Reg. 17 good governance, as accurate records had not been maintained for each person. You can see what action we asked the service to take at the end of this report.

The building was clean and well decorated. The furniture was in good condition and there were a few communal areas for people using the service including a garden. There was a gym area equipped for therapeutic use under the supervision of the therapy staff.

People using the service said they felt the staff were caring. We observed staff going about their work and saw that they were patient and caring towards people. People's dignity and cultural backgrounds were respected.

People received care that was personalised to them and reflected their preferences as well as their needs. Though there were not a lot of activities going on the people we spoke with felt that the focus on recovering and getting home was more important.

The staff had received training in End of Life care though this is not routinely provided at this service due to the focus on recovery and the relative shortness of the time people are there, usually three to six weeks.

The registered manager and other staff were accessible, approachable and responsive during the inspection. The staff reported they felt the service was well managed and that the registered manager and other team leaders were clear about the standards of care expected. Staff were deployed effectively and knew who they were supporting each day.

The service was seen to have responded to incidents effectively and learned from experience. There were on-going efforts to improve and standardise some processes such as assessments and records between the health and social care teams based there.

There was an auditing system in place to ensure that care and support had been provided as detailed in the care plans. We found that these audits had not identified some of the gaps we had found in record keeping during the inspection. There was no evidence that care had not been delivered but the gaps in the records meant we could not be certain. The home responded immediately and identified what they would do in an action plan.

This was a breach of Reg. 17, good governance, as monitoring systems had not identified gaps in record keeping. You can see what action we told the service to take at the end of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe in relation to the management of medication. Medication was not always stored safely. Medication records were not consistently completed.

People using the service said they felt safe, especially when being supported to mobilise.

People were protected from the risk of harm and abuse. Staff recognised what might be a safeguarding matter and knew how to follow the service's policies to report this.

Risks relating to the people using the service were assessed and management plans developed to mitigate these.

The building, utilities and equipment were maintained and serviced when required.

Is the service effective?

Good

The service was effective

People's needs were comprehensively assessed and support plans developed to meet them.

The service had an effective training system in place including, induction for new staff, refresher training for existing staff and 'pop up' training sessions around areas of interest suggested by the staff. People using the service felt the staff had the right skills to support them.

The staff received supervision regularly in line with the service's policy.

The staff were aware of the principles of the Mental Capacity Act 2005 and understood the importance of consent. People using the service said that staff asked them before providing care.

Is the service caring?

Good

The service was caring.

People using the service and their relatives praised the caring attitude of the staff.

We observed staff behaved in caring and kind ways when supporting people.

People were closely involved in developing their goals and independence.

People using the service felt their dignity and respect was valued.

Is the service responsive?

Good

The service was responsive.

People received care that was personalised and responsive to their needs.

People's care plans included information about what was important to them, their interests and previous experiences.

There were clear systems in place to ensure the safe transition of people between different services, for example, hospital or returning home with support.

People were protected against discrimination.

There was a complaints policy which all people were given access to when they arrived.

End of Life care is not provided routinely because the service is for 'intermediate care' Staff had however, had training should they need to provide this service.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Audits of records had not always picked up on some areas of concern identified in this inspection.

People using the service and their relatives felt that the home was well run.

Staff working at the service felt that the service was well managed and found the registered manager and management team were approachable and clear about expectations.

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Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The service was last inspected in June 2016 and found to be good overall with a breach of the Regulations in relation to safe management of medication.

Prior to the inspection we reviewed all of the information we held about the home in the form of notifications, previous inspection reports, expected/unexpected deaths and safeguarding incidents. We contacted Commissioners, Healthwatch and Wigan local safeguarding team. This would indicate if there were any particular areas to focus on during the inspection.
The inspection took place on 8 and 9 January 2018, the first day was unannounced which meant the service did not know we were coming. The second day was announced.

The inspection team consisted of; two adult social care inspectors, an Expert by Experience (ExE), an ExE is a person with personal experience of using or caring for someone who uses this type of care service. The ExE at this inspection had expertise in in caring for older people, people living with dementia and people who used care services. There were also, two specialist advisors; a nurse with experience of pressure care and an occupational therapist with experience of moving and handling. An inspection manager observed this inspection. We observed staff when they supported people to mobilise using equipment including; standing aids, hoists and walking frames. We observed how staff provided care and support during the inspection.

As part of this inspection we spoke with the registered manager, 18 members of staff, 13 people who used the service and five visiting relatives. We looked in detail at the care records for eight people. We looked at documentation held by the service including: policies and procedures and a range of records the home kept

in relation to; safeguarding, whistleblowing, Mental Capacity Act 2005 (MCA), Deprivation of Liberty Safeguards. The inspection team observed care practices. We looked at staff records including; recruitment, rotas and staffing levels, training, supervision and appraisals. We examined the records of accidents and incidents, infection control, building and environmental checks.

Requires Improvement

Is the service safe?

Our findings

We brought this inspection forward as a result of the coroner's findings and the issue of a Regulation 28: Report to prevent future deaths. We looked in detail at how the service managed the risks associated with moving and handling. The Coroner's report had identified some concerns in relation to whether staff had been adequately trained in the use of a hoist. We found all staff had received moving and handling training, following the incident. The training included; use of hoists, standing aids and slide sheets. Staff were not allowed to use any moving and handling equipment until they had been assessed as competent. All staff interviewed were clear about how they would maintain people's safety when moving and handling. Staff spoken with said they felt there had been changes for the better in the service around this issue and they felt their practice had improved as a consequence. This showed the service had responded to the concerns raised.

There was a clear policy in place to assess people's mobility needs on admission from the hospital. The hospitals were required to provide accurate information about the persons mobility needs when discharged. The service checks this with the person and develops a moving and handling plan. People were assessed by a therapist such as an occupational therapist (OT) or physiotherapist (PT) who are able to develop moving and handling plans and prescribe equipment. Where a person was admitted out of hours, such as at weekend, the home followed the safest option until the person could be assessed. An example would be using a hoist for a person who might be able to use a standing aid to avoid the risk of falls until they had been properly assessed by therapists.

Staff were observed supporting people to mobilise. The staff were seen to follow good practice; they were sensitive to the person and spoke with them during the moves. Staff were confident and clear in their communications and provided good advice. One staff member said; "please don't walk without someone with you, if you need to go to the bathroom or want to go to bed press this button and someone will come to help you." Staff reported that if they had any doubt they would take the safest option until someone had been assessed by a therapist. Both the OT and PT reported staff had sought their advice twice that morning. This showed the staff were aware of and following the policy. Staff informed they received a lot of information about moving and handling from the Multi-disciplinary Team Meetings (MDT). They reported communication had improved with the increase in the number of these meetings.

There was a falls risk assessment in each person's care file. This consisted of a tick list which identified their ability and areas of risk in relation to mobility and falls. A score was attributed to each answer which when added together would indicate the overall risk rating. In three of the files the totals had not been completed. This meant the overall level of falls risk had not been determined and it was not always clear whether a specific action plan was needed to manage the risk. Different paperwork was used to assess mobility and moving and handling risks by; the service the integral stroke unit and the therapists. The service had made efforts to combine their paperwork but an agreement between them and the health care provider was yet to be achieved.

The coroner's report had also identified concerns about the accurate recording of incidents. Following a

root cause analysis the service had ensured that records were made in a timely manner. The service have also established multi disciplinary post incident meetings to share information and knowledge. This showed the service had responded to the concerns raised.

The people we spoke with said they felt safe. One person said, "Staff are very good, they help me to get up, take me for walks, I feel safe, yes." Another person said, "I do feel safe here, I've never fallen here." A visiting relative said, "It is very safe here, I can't fault it."

Safeguarding is concerned with protecting people from the risk of harm or abuse. The service had a robust safeguarding policy with responsibilities identified in a flow chart. Staff were knowledgeable about what might be a safeguarding concern and how to raise this. One member of staff said, "...we have training on this. I know what to look for. I would report any concerns to [Registered Manager RM], who would then contact the local authority" Another member of staff said, "I know what to look for. I would report any concerns to [RM], if not in then the nurse in charge." A third member of staff said, "It can be about the way you speak to people, you should not use abusive language. If I was worried I would go and tell someone, senior staff or CQC." The service also had a clear whistleblowing policy which was displayed in some of the communal areas and was accessible to all service users, visitors and staff.

People were protected from discrimination. The service had experience of supporting people from a broad range of cultural backgrounds, in part, due to the rapid turnover of people accessing the service. Staff were aware of the importance of treating people equally and fairly. One member of staff said, "I think the home promotes equality, for example if a person needed Halal foods then we just let the kitchen know. It doesn't matter what colour or religion or sex they are - everyone is treated the same."

At the last inspection there had been a continued breach of the Health and Social Care Act (HSCA) 2008, (Regulations 2014), Reg. 12 (2)(g) Safe care and treatment; the proper and safe management of medicines; in relation to people who were self-medicating and the management of anticoagulants.

At this inspection we found there had been some improvements. Management of anti-coagulant medication was seen to have improved, a clear process was in place to ensure accurate administration, including for those who were self-medicating. People who were self-medicating were properly assessed and, if they were competent, were supported to manage their own medication. However, on checking with four people who were self-medicating in their rooms, peoples' medication was not stored safely. We saw in three people's rooms' medication being kept in polythene bags on the floor by their feet and another kept their medication in a plastic container on the bedside table. One person did not have any furniture in which to store their medication. Another person had a lockable piece of furniture in their reach but said they preferred to keep their other stuff in this. When asked if the staff had encouraged them to put their medication away they said they hadn't. A third person's medication was seen to be left unattended in their bedroom in a plastic box on their bedside table. The patient was out of the room for at least a quarter of an hour and the door was propped open. This meant there was a risk that medication could have been taken by someone else.

Topical treatments, such as creams, are applied by the care staff and recorded on a chart known as T (Topical) MAR. There were gaps found in the signing of these charts for three people and a fourth person did not have a chart in place despite having prescribed cream applied by the care staff. This meant we could not be confident people had received the correct treatment. Some staff commented that it was more difficult to record due to all charts being kept in an office to maintain confidentiality.
On two occasions medication was seen left unattended on top of the medicines trolley. The trolley was locked and the medicines were unattended for very short periods of time but there was a risk the unattended medication could have been taken by someone in error.

This is a breach of Regulation 12 (2)(g) of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014, the proper and safe management of medicines. The service responded immediately following this inspection and installed individual lockable medication cabinets in the bedrooms.

Medication Administration Record (MAR) charts were completed by hand, when people arrived and amended if there were any changes. Some of these were difficult to read which could lead to errors. We found the stock records of medication were not always accurate, when new medication was delivered this was not always reconciled with the balance on the MAR, this meant it was not possible to know how many tablets there should be in stock or to check whether people had received their medication as prescribed. One person had a weekly medication; the amount in stock did not tally with the amount signed as given. This meant there is a potential for medication to have been signed for but not given.

We looked in detail at how the service managed the risks associated with pressure care and treatment. There had been a complaint raised by a former service user about this matter. We found the service had a robust approach to pressure care, including assessing risks on admission, identifying treatment plans and reviewing these at regular intervals. Staff had received training in pressure care, 16 were 'Pressure Ulcer Champions', this meant they had received enhanced training and were able to advise their colleagues if required. At the time of the inspection staff reported there was no-one with a pressure ulcer.

The service had effective infection control policies in place. Personal protective equipment (PPE), such as; gloves, aprons, soap, paper towels, hand gel were available in the bathrooms and other communal areas. The building was clean throughout and free from offensive odours. Cleaning products were stored safely and Control of Substances Hazardous to Health (COSHH) forms were in place for all cleaning products in use. The service had a full range of policies and procedures as well as audits and monitoring to ensure standards had been maintained.

Health and safety checks were carried out on a regular basis. Fire risk assessments had been completed along with a record of fire systems, emergency lighting and fire alarm checks. Records showed arrangements were in place to check, maintain and service fittings and equipment. Gas safety and electrical equipment tests were up to date.

The service had plans in place to respond to events which may affect their operation such as, infection outbreak, power cut or heating failure. Individual risk assessments and management plans had been generated for each eventuality, to ensure staff knew what action to take.

Staffing levels were calculated according to the needs of the people accessing the service. Staff reported feeling that they had enough time to support people safely. There was a daily work schedule file which was completed each morning to plan staff deployment and included break times. Staff had also been allocated to specific people they would be responsible for throughout the day. This showed that the service was responding to the needs of the people who used the service on a daily basis. On the day of the inspection two staff had reported in sick. The registered manager quickly re-allocated staffing to manage this and requested agency staff.

We looked at five staff personnel files to check if safe recruitment procedures were in place. We found robust checks were completed before new staff started. The files included; an application form, interview notes, proof of identity and at least two references. Each file contained evidence that a Disclosure and Barring check had been completed. A DBS is undertaken to determine that staff are of suitable character to work with vulnerable people.

Good

Is the service effective?

Our findings

Alexandra Court provides intermediate care which is typically for between three and six weeks. The service focussed on goals and outcomes. People's needs were assessed on admission using information provided by the hospital and talking with the person themselves and their relatives. Outcomes were identified and a date for discharge was established within 48 hours of admission. These were regularly reviewed in care plans. The service made continued effort to work with partner organisations to agree a single assessment process and shared paperwork to improve consistency for people using the service.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions, with help to do so when needed. When they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and the least restrictive option possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We found information on display in the service regarding the principles of the MCA and DoLS which the service aimed to adhere to. At the time of the inspection nobody using the service had a DoLS in place, with all but one person assessed to have capacity to consent to care and treatment. For the person potentially without capacity we saw evidence the social worker attached to the service was in the process of completing an assessment to determine whether a best interest decision was necessary.

We checked whether the service was working within the principles of the MCA. We asked staff about their understanding of the legislation. The staff we spoke with confirmed they had received training and had an understanding. We saw on the training matrix 32 out of 35 staff had completed this training.

People using the service said the staff sought their consent to receive care and treatment. One person said, "Staff always check with me first." There was evidence in people's care plans the home had discussed consent and where the person was unable to be involved in the discussion the service had consulted with family instead. The staff we spoke with were aware of the importance of consent when providing care and treatment. One staff member said, "I ask for their consent. Even for the smallest thing you need to ask. If they say no, I try to explain what I want to do and why, if they still say no, I accept this and document it in their file." Another staff member said, "I explain what I would like to do and ask if this is okay." A third staff member said, "We respect peoples' right to choose, I would encourage people to make their own choices, if it was unsafe I would explain."

Staff training was seen to be comprehensive and up to date. New staff received an induction. Training was provided at different levels and frequency depending on the skills and experience of the staff. The registered manager maintained a training matrix which showed the training each member of care and nursing staff had received and when refresher training was due. Training was delivered face to face and online. The

service had access to training from colleagues across the provider including the registered manager from a neighbouring service with a specialism in moving and handling. In addition to the required training the service also provided 'pop up' training sessions around topics staff were able to suggest. This showed the service encouraged staff to learn and develop their skills and knowledge beyond the essential requirements.

At the previous inspection there were concerns staff had not received regular supervision. At this inspection we found staff received regular supervision. The service was adhering to its' own policy of providing supervision every three months. One member of staff said more supervision might be better but felt able to ask anyone for advice if they were not clear about something.

There were systems and procedures in place to facilitate a smooth transition between services. On arrival a 'hospital admission form' was partially completed in case re-admission was required. Once fully completed this would ensure the hospital had the most up to date information available, to facilitate a smooth and successful admission. Staff at Alexandra Court worked closely with other professionals involved, the person and their relatives, to ensure adequate arrangements were in place for any transition. Discharge planning meetings, chaired by the attached social worker, were held when a discharge was more complex or there were concerns about the ability of the person and their carer to manage. This ensured all parties were in agreement with the plan moving forwards and the right support and equipment was available. In addition the service held joint meetings (MDT's) three times a week to improve communication between, health and social care staff within the service. Staff commented they feel this has been a positive step.

People we spoke with said they had enough to eat and drink and said the food was alright. One person said, 'There is lots to drink if I want it" another person said, "The food is ok, I like spicy food though, they don't do that." We observed one meal service and saw people were offered a choice of food and drink, the tables were set with linen and condiments and the staff were quiet and helpful. We looked at how the home managed people's nutrition and hydration needs. We saw a 'nutritional assessment tool' had been used to record any issues with eating, drinking or weight loss. This information had been used to determine the interventions used to manage any risks. Information was a recorded on a daily care interventions document, which included fluid intake, food offered and eaten, elimination, oral care and pressure relief. Staff reported they did not always complete the charts, especially when they were kept in the office. There was no evidence of dehydration or harm. In relation to weights, there were some inconsistencies in recording. We saw evidence of a person being weighed in the daily notes but this was not on their weight record. We discussed this with the registered manager who addressed the record keeping straight away.

We found the service was effective with supporting people on fluid restriction programmes, which had been prescribed by the GP or hospital. We looked at the care charts of two people whose fluids needed to be under 1500mls per day, and saw this had been adhered to consistently.

The home was clean and bright and free from any unpleasant odours. Bedrooms and communal areas were decorated to a good standard and there was a variety of communal areas available. The ground floor gave access to the garden. There was a gym containing rehabilitation aids and equipment used by the therapists when supporting people with their rehabilitation.

Good

Is the service caring?

Our findings

People who were using the service told us they felt staff were caring. One person told us, "They are really kind. Go above and beyond for me." Another person told us, "They take care of me well." A third person said, "They are very caring but very busy". During the inspection staff were observed to act in kind and caring ways. Staff were seen to be attentive and patient and did not rush people when they were busy. People being supported were at ease and able to take their time, especially when transferring and moving about in the building. One person said, "If I am not ready staff are ok with this. Not pushy."

On the first day of inspection we found at least eight bedroom doors were wide open at 7.15am, with the occupants fast asleep. It was not clear whether the person had requested this. The registered manager told us it was down to the individual's preference, and sometimes this changed on a day to day basis which is why it is not captured in the care files. This appeared to be a reasonable account because people accessing the service were discharged from hospital and may have felt reassured by having their door open. We spoke to the registered manager about this, who told us people were consulted about their preferences each evening.

People's dignity and respect was seen to be valued, with staff able to explain how they achieved this and we observed positive staff interactions. One staff member told us, "When washing people ensure doors are closed, use towels and ensure people are covered up." Another staff member said, "I try not to expose [people] cover up as much as you can." A person using the service said, "They knock on my door before coming in." We saw some people had signs on their door asking people to knock and wait for a reply. Staff were observed to respect this request. The service displayed their visiting times in order to support protected meal times.

People were involved in decisions about their care. One person told us, "yes I'm involved with what is going on. I'm moving and I know that." A visiting relative said, "Yes, I'm kept informed of progress, I feel informed of what the stages are." A member of staff told us, "When people come in we do the 'meet and greet', as part of this they are asked for their opinions, what they want, how they want to be addressed, time they want to get up and go to bed. We get as much information about their choices as we can." Another member of staff told us, "I like to sit with them and have a chat, what they used to do, what they like."

The service promoted independence by setting goals with people as part of their care plan. This happened at the time of admission and was reviewed regularly during the few weeks the person was there. Re-ablement is a time limited programme to support people regain skills they may have lost during a hospital stay possibly due to injury or infection. People accessing the service said, "I am going home today it's been brilliant." another person said, "They have been marvellous with me and I am working on getting back home. I feel now that I will be able to because they have helped me a lot."

We asked the staff how they supported people to maintain their cultural identity and expression. Staff were able to describe how this was part of the 'meet and greet' they completed when people arrived. Staff were knowledgeable about different religious backgrounds and how this might affect someone's needs. Staff

were experienced with supporting people with their gender identity and demonstrated sensitivity in responding to these needs.

We saw from speaking with people accessing the service and viewing their care plans how effective communication had been established. This had included using interpreters for other languages including signing. This showed the service cared about including people.

Information about advocacy services was displayed on the noticeboard. We also noted the involvement of advocates within people's care, where no family or Lasting Power of Attorney was identified. This showed the service saw individuals' rights as important.

Good

Is the service responsive?

Our findings

People received care that was personalised and responsive to their individual needs and preferences. On admission an assessment was completed with the person and their relatives if preferred. There were self-assessment questionnaires which evidenced people were involved in their own assessment process. There was a detailed one page profile outlining individual needs and preferences, how best to communicate, the reason for admission and a summary of what they wanted to achieve. This meant that staff and other professionals would be able to see at a glance what was important in relation to care and support for that person. This was particularly useful in this environment where there was a rapid turnover of service users. The remainder of the care file included care needs in more detail and risk assessments specific to the individual.

In the eight case files we looked at we saw that daily notes were clear and thorough. Identified goals were reviewed regularly, sometimes weekly, and updated to reflect changes in needs. People and their relatives were involved in the reviews and updates of their progress and plans to return home. This ensured they felt confident and had the right support and equipment available.

The service did not provide end of life (EOL) care regularly due to being an intermediate care facility. At this inspection there was no-one identified as being at end of life. It was noted that staff had received training in this area including the nursing staff and the service had the skills and knowledge necessary should they be required.

We looked at how the service shared information with people who accessed it. In addition to the initial assessment the care staff completed a 'Meet and Greet' pack with people. This included letting people know about the service, what to expect and how to raise any concerns. Staff found it provided a useful opportunity to meet with people and get to know them more broadly, including their interests and hobbies or what work they did. People had access to a call bell system and we saw that this was in people's reach and they were encouraged to use it.

The majority of people accessing the service remained in their rooms, coming out into the communal areas at meal times only. People we spoke with said; "The only activity is going for my meals in the dining room." another person said "It's only a stop gap so no need to entertain me." Relatives we spoke to said, "From what I can see she is happy to watch TV in her room." Another relative said, when asked about activities, "They are getting her better to go home, that's good." Some activities were available including social activities and outings if people wanted to do something.

We looked at how the service responded to complaints. The notice board on each floor had a copy of the complaints procedure, which meant it was accessible to all people at the service. There was a complaints file in place, which included the policy and procedure for managing concerns. Each complaint received was stored separately in a plastic wallet and included all associated documentation for example, statements, meeting notes and copies of the response. Each complaint had a detailed reply explaining the action that had been taken. Each quarter a 'Complaint summary' had been completed, looking at each one, what had

occurred, people and professionals involved or contacted and actions taken, the outcomes and date resolved. This ensured oversight into the complaints procedure had been maintained. People we spoke with felt able to raise a concern if they had one. One person said, "No complaints, if I did I would go to the office."

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager at the home. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Staff we spoke with felt the service was well managed and commented on the skills, knowledge and accessibility of the registered manager. One person said, "I feel supported by the manager because she is very clear about standards and expectations of staff." Similarly other staff said they had felt supported and had seen changes for the better in their practice; mentioning in particular, the improved communication following the instigation of the multi-disciplinary team meetings three times each week, and the increased training and information around moving and handling. The registered manager was visible throughout the inspection, staff and service users knew who they were and said they felt able to approach them at any time.

The service had systems in place to monitor and assess service delivery. They completed audits of key areas of health and social care provision, including; medication, pressure care, daily records, nutrition and hydration, infection control and training. We found that the audits did not identify all the issues we had found during the inspection. For example, lack of clarity on the medication records, gaps in the signing for topical cream application, nutrition and hydration charts not being completed and turning charts for pressure relief not being consistently completed.

This is a breach of Regulation 17(2)(a) of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014; assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity, and Regulation 17(2)(c) maintain securely an accurate, complete and contemporaneous record in respect of each person including a record of the care and treatment provided to them.

Staff meetings were held regularly, at least monthly, there were also separate meetings for care staff, nurses and team leaders. Staff reported the meetings were informative and they felt able to raise any areas they wished to. This showed that the service was engaging with staff and encouraging their input.

There was a clear management structure in place. Each unit completed a handover at every shift change. We witnessed the handover between night and day staff on the first day of inspection. Each person on the unit was discussed including new admissions. Information was detailed and was also recorded in a handover pad for staff to refer to. There was a daily work schedule file which was completed each morning to plan staff deployment. Staff had been allocated to specific people they would be responsible for throughout the day. This meant staff were clear about what they needed to do. One member of staff commented, "I love the way the units are run, I think, we have a fantastic manager, all the carers get on really well. I think the patients can relax." The service had also increased the multi- disciplinary team meetings from once a week to three times a week. We attended one of these meetings and found that

individuals needs and updates were thoroughly discussed and the different roles of the health and social care staff were clear. This demonstrated the services commitment to improvement. Staff had reported the improved communication and quality of information available was a result of the increased meetings.

We looked at whether the home had made all the necessary statutory notifications to CQC. In part, this was in response to information we held about events that had happened. The registered manager was able to provide a detailed account of the events and their response. We were satisfied that the service had made the necessary notifications when required.

The views of the people who used the service were actively sought. There was a quality assurance questionnaire included in the information provided to people when they were admitted. People were encouraged to fill these in to allow the service to consider their views. There was also a suggestion and comments box. Each year the service circulated quality assurance questionnaires to stakeholders. The most recent one was in the process of being analysed. At the previous inspection the service was found to have responded to any concerns raised, either managing them as complaints or changing their practice and service delivery. We could see the results of the previous survey on display in the reception area. There were many cards on display that were highly complimentary of the service provided.

The service had a business continuity plan in place to respond to events which may affect the operation of the home, such as; an infection outbreak, failure of utilities or heating failure. Individual risk assessments and management plans were in place for each eventuality to ensure staff knew what action to take.

The service had comprehensive policy and procedure files. They were stored both electronically and in three themed files. This meant they were accessible to anyone that needed to see them. Staff reported knowing where they were and when to refer to them. The policies and procedures related to; maintenance, health and social care practices and safeguarding. At the previous inspection some policies were found to have not been reviewed when necessary. At this inspection we found that all policies and procedures were up to date and had been reviewed when required.

The service is working closely with partner organisations including; Wigan CCG, Bridgwater NHS Trust and Quality Improvement. Efforts have been made to develop unified paperwork and assessment processes to improve the quality of the service. These negotiations were on-going.

In response to this inspection the service developed an action plan to address all the concerns we raised. We will be looking at the results of this at our next inspection.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 (2)(g) - the proper and safe management of medicines. The provider had not ensured that medication was stored safely. The provider had not ensured that medication was records were accurate.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17(2)(a) assess monitor and improve the quality and safety of the service. The provider did not have an effective system in place to ensure effective record keeping